



**INLAND COUNTIES EMERGENCY MEDICAL AGENCY**

*Serving San Bernardino, Inyo, and Mono Counties*

**515 N ARROWHEAD AVENUE  
SAN BERNARDINO, CA 92415-0060  
909-388-5823 FAX: 909-388-5825**

**EMT-PARAMEDIC ACCREDITATION/BI-ANNUAL RENEWAL**

- ☐ **Initial Accreditation (\$75.00)**  
☐ **Bi-Annual Renewal (No Fee)**

*Fees are Nonrefundable - Cash or Money Order Only - NO PERSONAL CHECKS ACCEPTED*

Legal Name:

\_\_\_\_\_  
Last First Middle Sex(M/F)

Address:

\_\_\_\_\_  
Number & Street City State Zip

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone #: \_\_\_\_\_ Drivers License # \_\_\_\_\_

SSN #: \_\_\_\_\_ Employer: \_\_\_\_\_

- ☐ Yes ☐ No As a prehospital provider has your certification or license ever been suspended, revoked, or placed on probation? **If yes**, attach an explanation including City, County, and State of action.

**Verification of Employment/Sponsorship as a Paramedic in the ICEMA Region**

*To be completed by an authorized ALS Provider Agency **or** by a provider Agency who has Formally Requested ALS Authorization in the ICEMA Region*

I verify that \_\_\_\_\_, EMT-P State License # \_\_\_\_\_ is currently/or will be employed at this agency as an EMT-Paramedic.

\_\_\_\_\_  
Agency Authorized Signature/Title Print Name Date

**Waiver: Local Orientation Class and five (5) ALS contacts.**

**Eligible applicants:** *Individuals who attended an EMT-P program in the ICEMA Region AND completed their field internship within the last six (6) months in the ICEMA region **with** an ICEMA authorized preceptor.*

ALS Provider Agency Name: \_\_\_\_\_ Preceptor Name: \_\_\_\_\_

Preceptor Signature: \_\_\_\_\_ ICEMA Accreditation #: \_\_\_\_\_

**ICEMA USE ONLY:** ☐ approved ☐ denied Name: \_\_\_\_\_

**ICEMA USE ONLY:**

State License #: \_\_\_\_\_ Exp. Date \_\_\_\_/\_\_\_\_/\_\_\_\_

BLS Exp. Date: \_\_\_\_\_

ACLS Exp. Date: \_\_\_\_\_

ICEMA Accred. #: \_\_\_\_\_

Effective: \_\_\_\_/\_\_\_\_/\_\_\_\_

Exp. Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Accounting #: \_\_\_\_\_

## EMT-PARAMEDIC ACCREDITATION/BI-ANNUAL RENEWAL

### Submit the following for Initial Accreditation:

- ☐ Copy of State License
- ☐ Copy of course completion certificate
- ☐ Cash or Money Order (No personal checks)
- ☐ Copy of current Drivers License (for ID purposes)
- ☐ Current photo taken within last 6 months (CDL size, no tinted glasses or hats)\*
- ☐ Copy of front and back of current CPR card\*\*
- ☐ Copy of front and back of current ACLS card

### Submit the following for Bi-Annual Renewal:

- ☐ Copy of State License
- ☐ Copy of current Drivers License (for ID purposes)
- ☐ Current photo taken within last 6 months (CDL size, no tinted glasses or hats)\*
- ☐ Copy of front and back of current CPR card\*\*
- ☐ Copy of front and back of current ACLS card
- ☐ Complete ICEMA Recertification Education Requirements (grid below)

\* Photo taken at ICEMA for no additional charge

\*\* CPR card must meet or exceed the current "Guidelines and Standards for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care"

### Document Bi-annual Renewal Education Requirements Below AND Provide Copies of the Roster or CE Certificate from Each Class Attended

**(FCA) FIELD CARE AUDITS ~ (SD) SKILLS DAY ~ (PUC) PROTOCOL UPDATE CLASS**  
**(For specific requirements please refer to ICEMA Protocol Reference # 15301)**

FCA	SD	PUC	CE Provider Number	CE Provider Name	Date	Hours

*I hereby certify that the information listed is true and correct and that I am eligible for accreditation. I understand that any fraudulent entry on this form may be considered cause for denial or subsequent revocation of my ICEMA accreditation with immediate notification to the State EMS Authority. I hereby authorize verification of any and all information contained herein and authorize release of any and all information as deemed relevant to my accreditation process to my employer. I agree to hold ICEMA harmless from any act or action resulting from the release of the information as stated above.*

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Signature / Date